Forms

*These are examples of possible forms to use from Idaho and other states.

CONTENTS

ID = Idaho

MT = Montana

OR = Oregon

WA = Washington

Introduction

The forms on the following pages are a collection of examples of various case management and data collection forms from TB programs in Idaho, Montana, Oregon and Washington State. Most of the forms are available electronically as MS Word documents. The MS Word files can be requested from the Idaho TB program at 208-334-5939.

While the all forms included in this section are meant to be resources, the following reports are required by the contract with the Idaho State TB Program:

Report Title	When Due
RVCT form*	When information is available
RVCT follow-up 1 form*	When sensitivities are available, or, if culture negative, once the laboratory declares the specimens to be culture negative.
RVCT follow-up 2 form*	At the end of regimen
Directly Observed Therapy Record	At the end of regimen
Contact Tracing Form	Return with RVCT Follow-up 2 form or when contacts complete evaluation or treatment
TB Control Activities Quarterly Report†	Quarterly

*The RVCT forms are not available in electronic format.

†The Quarterly Report is not included in this manual, but can be requested at from the Idaho TB program.

CONFIRMED/SUSPECTED REPORT OF TUBERCULOSIS DISEASE

Montana Department of Public Health & Human Services
TB Program, Cogswell Building, Room C-216
1400 Broadway, Helena, MT, 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date: _____
Submitted By: _____

Phone: _____

Patient Name: _____ Age: _____ DOB: _____
City: _____ County: _____ State: _____ Zip Code: _____
Country of Origin: _____ If not USA, month & year of Immigration: _____

Gender: ( ) Female ( ) Male
Race: ( ) White ( ) Native American ( ) Other, specify: _____
Ethnic Origin: ( ) Hispanic ( ) Non-Hispanic

Diagnosis Date: _____ Date first suspected: _____
Site: ( ) Pulmonary ( ) Bone/Joint ( ) Lymph ( ) Miliary ( ) GU ( ) Pleural ( ) Other _____
Re-disease after 12+ months of inactivity: ( ) Yes ( ) No List year of previous diagnosis: _____
Diagnosis reported at time of death: ( ) Yes ( ) No Date expired: _____
Contact of known TB case: ( ) Yes ( ) No Name of case: _____

1. Tuberculin Skin Test Results: Date: _____ mm of Induration: _____
2. X-Ray Results: Date: _____ Results: _____
   Attach X-ray results
3. HIV Results: Date: _____ Results: _____

4. Bacteriological Results: **If state lab is not used, attach lab results. If state lab is used, results are on file at the TB program**.

Initial Medication Regime: ( ) INH ( ) Rifampin ( ) Pyrazinamide ( ) Ethambutol ( ) Other _____
Date Therapy Started: _____ **DOT Plan**: (dose, freq, location) _____
_____
_____
Brief Clinical History: _____
_____
_____

Resident of Correctional Facility: ( ) Yes ( ) No Facility Name: _____
Resident of Long-term Care Facility: ( ) Yes ( ) No Facility Name: _____
Homeless within the last year: ( ) Yes ( ) No Shelter Name: _____
Occupation: Check all that apply within the past 24 months
( ) Health Care Worker ( ) Migratory Agricultural Worker ( ) Unknown
( ) Correctional Worker ( ) Not employed past 24 months ( ) Other specify: _____

Injecting Drug use within Past Year: ( ) Yes ( ) No ( ) Unknown
Non-injecting Drug use within Past Year: ( ) Yes ( ) No ( ) Unknown
Excess Alcohol Use within Past Year: ( ) Yes ( ) No ( ) Unknown

Liver Disease: ( ) Yes ( ) No ( ) Unknown ( ) Hepatitis A, B, or C Type: _____
Diabetes: ( ) Yes ( ) No ( ) Unknown ( ) Type I ( ) Type II
Organ Transplant: ( ) Yes ( ) No ( ) Unknown Transplant Date: _____ Type: _____

Attending Physician: _____ Phone: _____

Public Health Case Manager: _____ Phone: _____

TB DIAGNOSTIC REFERRAL FORM:
Active TB Disease or Latent TB Infection (LTBI) ONLY

Today's Date _____

Agency _____ Contact _____
Address _____ Title _____
Phone/Fax_____ Phone _____

Patient Name _____
Address _____ City _____
DOB _____ Sex _____ Race _____
Attending Physician _____ Phone _____
Public Health Manager _____ Phone _____

This person is being referred because he/she had a Positive Tuberculin/TST Result:
Date _____ Induration in mm _____

Reason for TST/Mantoux:
( ) Contact of known TB case
( ) Foreign born; Country of origin _____
( ) Occupational _____
( ) Other _____

FURTHER DIAGNOSTIC TESTS REQUIRED: (Core Curriculum; 4th Edition, 2000)

A complete medical evaluation for TB includes*: **1. Tuberculin/TST skin test; 2. Chest X-ray; 3. Medical history; 4. Physical examination; and 5 .Bacteriological or histologic exam if needed based on symptoms and chest X-ray**

Chest X-ray
Date _____
Results _____
Previous X-ray dates & results _____

Symptoms
( ) Productive, prolonged cough ( ) Chest pain ( ) Hemoptysis
( ) Weight loss ( ) Appetite loss ( ) Tires easily ( ) Night sweats
( ) Fever ( ) Chills

Physical Exam
_____
_____
_____

Risk Factors For Treatment
Liver Disease ( )Yes ( )No ( ) Hepatitis A, B or C Type ____
Diabetes ( )Yes ( ) No ( )Type I ( )Type II
Organ Transplant ( )Yes ( )No Date _____ Type _____
Injecting Drug Use within the past year ( )Yes ( )No
Non-Injecting Drug Use within past year ( )Yes ( )No
Excess Alcohol Use within past year ( )Yes ( )No
Other Comments: _____

Diagnosis ( ) Presumptive/Active TB - **notify your local health department ASAP**
( ) Latent TB Infection (LTBI), Active TB Disease ruled out.

*Treatment LTBI _____

* Until Active TB disease is completely ruled out, DO NOT start patient on medications for treatment for Latent TB Infection (LTBI).

Treatment recommendations for Latent TB Infection: **1.** A 9-month regimen of INH is considered optimal for both HIV-positive and HIV-negative adults; **2.** A 6-month regimen may also provide sufficient protection. **3.** Pyridoxine (Vit B6) is often given to reduce the incidence of INH induced peripheral neuropathy when INH doses exceed 5mg/kg or the patient has HIV, diabetes, alcoholism, malnutrition, pregnant, seizures. ***Core Curriculum on TB, 4th Edition, 2000.*** http://www.cdc.gov/nchstp/tb/pubs;slidesets/core/html/trans6_slides.htm

Monitoring Protocol

1. Baseline liver panel for patients with HIV, alcoholism, history of liver disorder, risk for liver disorder, pregnant and immediate postpartum
2. Monthly follow-up to evaluate adherence and signs & symptoms of active disease
3. Weekly to monthly (depending on meds) follow-up to evaluate for signs & symptoms of hepatitis

Physician _____ Phone _____

Your Local Health Department offers the following services for patients with Active TB Disease and Latent TB Infection (LTBI):*

1. Help obtaining anti TB medications
2. Regular monitoring of patient adherence
3. Regular monitoring of patient's for changing signs and symptoms of TB
4. Regular monitoring of adverse reactions to anti TB medications
5. Regular communication with prescribing physician

*If you are referring this patient to the health department for treatment monitoring please send the original Rx for INH and Pyridoxine (if prescribed) to your local health department or with the patient.

Please return this form to the _____
(Local health department name & contact person)

Bacteriology Data Sheet

Patient Name _____

Lab Number	Submitted By	Date Collected	Date Received	**AFB Smear Results**	Date Reported	**Culture Results**	Date Reported	**NAA Results**	Date Reported

Susceptibility Results:

Date		INH	S / R
Date		RIF	S / R
Date		EMB	S / R
Date		PZA	S / R
Date		STREP	S / R
Date			S / R

BIOCHEMISTRY DATA

Patient name: _____

DATE									
WBC									
RBC									
HGB									
PLT									
AST									
ALT									
TBIL									
DBIL									
ALKPHOS									
ALBUM									
Serum Drug Levels									
INH									
RIF									
EMB									
PZA									

DATE									
WBC									
RBC									
HGB									
PLT									
AST									
ALT									
TBIL									
DBIL									
ALKPHOS									
ALBUM									
Serum Drug Levels									
INH									
RIF									
EMB									
PZA									

TB HOME EVALUATION

Home Environment

Client has own room: ☐ Yes ☐ No # bedrooms/comments: _____
Residence: ☐House ☐Apt/Condo ☐Mobile home ☐Motel/Hotel ☐ Shelter ☐ Institution ☐Other/Homeless
Housing Assistance: Section VIII ☐ Yes ☐No *or* HUD ☐ Yes ☐No
in dwelling: Adults___ Children___ . Among them, Immunosupressed**:** ☐ Yes ☐No Who _____
Adequate food resources: ☐ Yes ☐No Adequate ventilation and heating: ☐ Yes ☐No
Safe place for storing medication: ☐ Yes ☐No
Home safety/ adaptive equipment: ☐ Yes ☐No Specify _____
Pets ☐ Yes ☐No
Assessment/Comments: _____
_____

Understanding of Disease

Education: ☐ < High School ☐High School ☐College ☐College +
Drug/Alcohol Risk Factors: ☐ Yes ☐No ☐ N/A, *if yes*, willing to seek TX ☐ Yes ☐No
Adequate knowledge of tuberculosis transmission: ☐ Yes ☐No
Medications:
Adequate understanding of medication side effects: ☐ Yes ☐No
Adequate understanding of medication schedule: ☐ Yes ☐No
Possible drug interaction:_____
Treatment Plan:
Understands need to keep doctor/clinic appointments: ☐ Yes ☐No
Understands need to comply with requests for CXR/Lab/ DOT: ☐ Yes ☐No
Assessment/Comments: _____

Social Interaction

Adequate culturally appropriate social support system: ☐ Yes ☐No If Yes, Whom:_____
Lifestyle consistent with treatment adherence: ☐ Yes ☐No Language limitations: ☐ Yes ☐No
Assessment/Comments: _____

Transportation

Client has a car: ☐ Yes ☐No Relative/Friend will transport? ☐ Yes ☐No
Client needs transportation: ☐ Yes ☐No Client has access to bus service: ☐ Yes ☐No
Knowledge of transportation assistance: ☐ Yes ☐No Client will need bus incentive: ☐ Yes ☐No
Assessment/Comments: _____
_____

Financial

Source of income: ___ Other sources: ☐Food Bank ☐Medicare ☐Food Stamps ☐WIC ☐ SSI
☐Other (Specify): _____
Assessment/Comments: _____
_____

Date: _____ Signature: _____

Copy on your letterhead

Date: _____

To: Postmaster
_____, Oregon_____

Address Information Request

Please furnish this agency with the new address, if available, for the following individual or verify whether or not the address given below is one at which mail for this individual is currently being delivered. *If the following address is a post office box, please furnish the street address as recorded on the boxholder's application form.*

Name: _____

Last known address: _____

_____

I certify that the address information for this individual is required for the performance of this agency's official duties.

_____ _____
Name Title

FOR POST OFFICE USE ONLY

( ) Mail is delivered to address given
( ) Not known at address given
( ) Moved, left no forwarding address
( ) No such address
( ) Other (specify):

New Address
_____
_____

Boxholder's Street Address:
_____
_____

Agency's Return Address:
as per letterhead

_____
Postmark/Date Stamp

Idaho Tuberculosis Drug Assistance Program
Order Form

Physician
Ship to:_____

_____

_____

_____

Patient: _____

Date of Birth: _____

Order Date: _____

Telephone: _____

*****Only order three (3) months supply at one time. You will need to re-order as needed.*****

Product No.	Amt.	Product	Price
3753-1		package(s) of Pyridoxine, 25 mg, (Vitamin B6), 100 tablets per package	0.00
2509-3		bottle(s) of Isoniazid, 300 mg, (INH), 30 tablets per bottle	0.00
2900-0		bottle(s) of Isoniazid syrup (INH), 1 pint bottle	0.00
2942-0		bottle(s) of Isoniazid, 100 mg, (INH), 100 tablets per bottle	0.00
3070-0		bottle(s) of Ethambutol, 400 mg, (EMB) , 60 tablets per bottle	0.00
3950-0		bottle(s) of Pyrazinamide, 500 mg, (PZA), 100 tablets per bottle	0.00
8621-0		bottle(s) of Rifampin, 300 mg, (RIF), 60 capsules per bottle	0.00
		TOTAL COST:	$ 0.00

Direct questions to: Sybrina Bobo
Phone: (208) 334-5939
Fax: (208) 332-7307

Office of Epidemiology and Food Protection
Idaho Department of Health and Welfare
450 West State Street, 4th Floor
PO Box 83720
Boise, ID 83720-0036

FOR OFFICE USE ONLY

Account No: 6738

Confirmation No: _____

Invoice Amount: _____

6/22/07

PANHANDLE HEALTH DISTRICT
TB DRUG INTERVIEW SHEET

Client Name: _____

Nurse's Initials:	Date ____ ____	Date ____ ____	Date ____ ____	Date ____ ____	Date ____ ____	Date ____ ____	Date ____ ____	Date ____ ____	Date ____ ____
HEPATOTOXICITY(ALL)									
Icterus (Jaundice)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Nausea	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Vomiting	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Abd Pain (RUQ)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Fever x 3 days or more	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Light Stools	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Dark urine	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
HYPERSENSITIVITY(ALL)									
Rash	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Arthralgia (Joint Pains)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
NON-SPECIFIC (ALL)									
Headache	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Malaise	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Fatigue	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Anorexia (Loss of Appetite)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
NEUROTOXICITY(INH,EMB)									
Paresthesia (Numbness,	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Tingling)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Hearing-decrease	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Balance-decrease	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Dizziness	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Visual-decrease/change	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Acuity	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
• Color	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
HEME (RIF)									
Bruising-increase	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Bleeding gums	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Hematuria (Blood in urine)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Hematochezia (Blood in stool)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

CIRCLE "Y" FOR YES AND DESCRIBE IN PATIENT PROGRESS NOTES
CIRCLE "N" FOR NO

Adverse Reactions & Side Effects to TB Medications

(Use with DOT Treatment Record Form)

Patient's Name: _____

							Comments
Date							
PHN Initials							
Hepatotoxicity INH,RIF,EMB,PZA							
Jaundice							
Nausea							
Vomiting							
Abd Pain							
Fever > 3 days							
Light stools							
Dark urine							
Hypersensitivity INH,RIF,EMB,PZA							
Rash							
Joint Pains							
Non-specific INH,RIF,EMB,PZA							
Headache							
Malaise							
Fatigue							
Loss of Appetite							
Neurotoxicity INH, EMB							
Numbness/tingling							
Hearing decrease							
Balance decrease							
Dizziness							
Vision changes							
Color							
Hemolytic RIF							
Bruising – increase							
Bleeding gums							
Blood in urine							
Blood in stool							

If any of these are present, describe in Monthly TB Patient Assessment and call treating MD ASAP.

MT DPHHS 2/2007

VISUAL ACUITY AND ISHIHARA'S TESTS FOR COLOR BLINDNESS - Test Results

Client Name _____ D.O.B ____/____/____ MR #:_____

Last Name First Name

Legend from Ishihara's Tests for Colour Deficiency Of Unlettered Persons

Number of Plate	Person with Normal Color Vision	Person with Red-Green Deficiencies
1	○	○
2	□	□
3	○	□
4	□	○
5	≀	≀
6	Red curve	Blue curve
7	Upper Green curve	Lower Red curve
8	X to X & back up to the starting X via the other line	Unable to trace, or Only traces one line X to X

Ishihara should be used for any person on EMB, including persons 4-6 years of age or persons who cannot read.

BASELINE		Client's Visual Acuity and Ishihara Test Results									
Date	**Tool***	**Date**	**Tool***	**Date**	**Tool***	**Tool***	**Tool***	**Date**	**Tool***		
Od(right eye)		**od**		**od**		**od**		**od**			
Os(left eye)		**os**		**os**		**os**		**os**			
Ou (both eyes)		**ou**		**ou**		**ou**		**ou**			
glasses	Yes/No	**glasses**	Yes/No	**glasses**	Yes/No	**glasses**	Yes/No	**glasses**	Yes/No		

1. Plates 1,2 and 5 are demonstration plates for the examiner to explain and show the patient what forms they will be asking the patient to identify and to verify patient's understanding.
2. For Plates 3,4,5,6,7, and 8: check (4) the appropriate column: "Norm" if patient result indicates normal; "Def" if the patient result indicates a deficiency. Mark (X) in the "Def" box if the patient can not read the plate.

Norm	**Def**	**Norm**	**Def**	**Norm**	**Def**	**Norm**	**Def**	**Norm**	**Def**

Nurse's Signature				
**Interpretation / Comments (Action)				

**Interpretation of Acuity & Ishihara results

1. Stable - for the patient: if no change from baseline
2. Abnormal:
   - Visual acuity changes more than one line from baseline.
   - Ishihara: can't recognize any curve in Plate #8.
   : **Questionable**- if misjudges more than 3 plates among # 3,4,6,and 7.
   : **Re-test-** if misjudges on 1 or 2 plates among # 3,4,6, and 7.

**follow instructions provided by the tool's manufacturer

***Tool** A = 10 foot acuity chart- Brand: Snellen, Sloan, other_____
B = 20 foot acuity chart- Brand: Snellen, Sloan, other_____
C = other: _____

Action: Follow-up recommendations for *changes* from baseline-
Baseline Test: no follow-up needed if Ishihara deficiency noted *before* EMB was started.
Susequent Test: - No change from baseline, or only 1 line change: No follow-up needed.
- Change from baseline: **Stop EMB if** decrease of acuity by 2 or more lines or any change is noted on Ishihara *from baseline* and refer to PMD for further evaluation.

Instructions for filling out the Visual Acuity and Ishihara Test Result form: **12/12/02**

1. Fill in the patient's name, DOB, medical record #.
2. Fill in page number (eg/ for patients on EMB for extended periods of time).
3. For both the Visual Acuity and Ishihara tests, follow the manufacturer's instructions for administering the test.
4. Circle the type of visual acuity tool used or enter the name of the tool used, if it's not listed. The same tool should be used from test to test.
5. Visual Acuity Section:
   - fill in the date of the test, and the tool used (per code at bottom of the page)
   - enter the visual acuity score for the right eye, left eye, both eyes, and indicate if corrective lenses were used by circling "glasses" Yes or No.
6. Ishihara Section:
   a. Demonstrate what you are looking for, O or □, in plates 1 and 2. Have patient do a return demonstration to assure they understand the instructions.
   b. For plates 3-8, check (4) the column which indicates the color detection ability of the patient: check (4) the "Norm" column if they scored normal, check (4) the "Def" column if the patient result indicates a deficiency in color vision. Mark (X) if the patient does not recognize any design in the plate. (For each plate, there is a column in the legend that reminds you what a normal and what a deficient person sees)
7. Compare the baseline to the current test result.
   a. On baseline test (done *before* the patient starts EMB)
      1) If visual acuity is abnormal, refer to MD for further evaluation and corrective lens as indicated.
         - If patient obtains corrective lenses (contacts or glasses), repeat the test to establish a new baseline with corrective lenses.
      2) If red-green deficiencies identified, no follow-up is indicated. If unable to recognize any of the shapes, refer to PMD for follow-up.

   b. On subsequent tests:
      1) No follow-up is needed if there is no change in visual acuity /Ishihara; or, only 1 line change in visual acuity.
      2) **Stop EMB *if*** there is a decrease of acuity by <u>2 or more</u> lines, or <u>any</u> change is noted on Ishihara. Refer to PMD for further evaluation and recommendation regarding continued use of EMB.
8. Sign in the Nurse's signature box.
9. Indicate "interpretation" by using the "Interpretation of Acuity & Ishihara results legend in the lower left corner of the form.
   -Note, if patient misjudges 1 or 2 plates (among plates 3,4,6,&7), and that is different from the baseline, repeat the test. If it is still a change from baseline, stop the EMB and call the PMD to report the findings and refer patient for further evaluation.
   a. If there is no change in visual acuity /Ishihara; or, only 1 line change in visual acuity, write in "stable".
   b. If there is a decrease of acuity by <u>2 or more</u> lines, or <u>any</u> change is noted on Ishihara, write in "abnormal" and where to look for notes explaining your intervention.

Treatment of Active Tuberculosis (TB) Education Form

Public Health Nurse: _____

Agency: _____

Phone: _____

Dear Client:

This is to inform you about the treatment, side effects and risks of taking medication for active tuberculosis disease.

Treatment of active TB with prescribed drugs will in most cases cure TB. The medication needs to be taken from 6 months to a year according to your physician's prescription and instructions.

Medication	Side Effects	Comments
Isoniazid (INH)	Dark Urine, Light-colored Stools, Fatigue, Loss of Appetite, Nausea, Vomiting, Abdominal Pain, Yellow Eyes or Skin, Rash, Tingling or Muscle Twitching in hands or feet	**Call your doctor or public health nurse if** you have any of these side effects. **Do not use alcohol** because of risk of liver damage. **Do not take Tylenol (acetaminophen)** or any medication with Tylenol while on INH. You can take Ibuprofen, Aleve or Advil. **Avoid antacids (Maalox, Tums, Mylanta)** within 2 hours of taking INH. **Tell your doctor or public health nurse if** you become pregnant while on INH. **Call your doctor or public health nurse if** you miss a pill.
Rifampin (RIF)	Orange colored body fluids, Flu-like Symptoms, Nausea, Vomiting, Abdominal Pain, Bleeding Problems, Fever, Light-colored Stools, Rash, Yellow Eyes or Skin, Fatigue, Blood in Urine, Bruise Easily	**Do not use alcohol** because of risk of liver damage. Significant interactions with methadone, birth control meds, digitalis, coumarin derivatives, anticonvulsants, PIs, NNRTIs, and many other drugs. Colors body fluids orange (i.e. sweat, urine, tears). May permanently discolor soft contact lenses. **Tell your doctor or public health nurse if** you become pregnant while on INH.
Pyrazinamide (PZA)	Dark Urine, Light-colored Stools, Yellow Eyes or Skin, Joint Aches, Upset Stomach, Nausea, Vomiting, Fatigue, Rash, Photosensitivity, Gout	**Do not use alcohol** because of risk of liver damage**.** Drink plenty of fluids (water, juices, milk). May cause elevated uric acid.
Ethambutol (EMB)	Any Changes in Vision, (Ability to see or discriminate color) Skin Rash	**Do not use alcohol** because of risk of liver damage. Not recommended for children who are too young to be monitored for vision changes.

CALL: **If you have any of the side effects listed above or**
If you have any questions: _____

I have read the statements on this form about the treatment of active TB disease. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of taking these medications.

_____ _____ _____
Client name, please print Date of Birth Today's Date

_____ _____
Client or authorized person signature Public Health Nurse Signature

List educational material given to client: _____

Gave client a copy of form: _____(PHN Initials)

Treatment of LTBI (Latent Tuberculosis Infection) Education Form

Public Health Nurse: _____

Agency: _____ Phone: _____

This is to inform you about the treatment, side effects and risks of taking medication for latent TB infection.

Treatment of latent TB infection, as prescribed, will prevent active TB disease from developing in most individuals. The medication needs to be taken from 6 to 9 months according to your physician's prescription and instructions. Rifampin is occasionally used if one is unable to take INH.

Medication	Side Effects	Comments
Isoniazid (INH)	Dark Urine, Light-colored Stools, Fatigue, Loss of Appetite, Nausea, Vomiting, Abdominal Pain, Yellow Eyes or Skin, Rash, Tingling or Muscle Twitching in hands or feet	**Call your doctor or pubic health nurse if** you have any of these side effects. **Do not use alcohol** because of risk of liver damage. **Do not take Tylenol (acetaminophen)** or any medication with Tylenol while on INH. You can take Ibuprofen, Aleve or Advil. **Avoid antacids (Maalox, Tums, Mylanta)** within 2 hours of taking INH **Tell your doctor or pubic health nurse if** you become pregnant while on INH. **Call your doctor or public health nurse if** you miss a pill.
Rifampin (RIF)	Orange colored body fluids, Flu-like Symptoms, Nausea, Vomiting, Abdominal Pain, Bleeding Problems, Fever, Light-colored Stools, Rash, Yellow Eyes or Skin, Fatigue, Blood in Urine, Bruise Easily	**Do not use alcohol** because of risk of liver damage. Significant interactions with methadone, birth control meds, digitalis, coumarin derivatives, anticonvulsants, PIs, NNRTIs, and many other drugs. Colors body fluids orange (i.e. sweat, urine, tears). May permanently discolor soft contact lenses. **Tell your doctor or public health nurse if** you become pregnant while on INH.

CALL: **If you have any of the side effects listed above or**
If you have any questions: _____

I have read the statements on this form about the treatment of latent TB infection. I have had an opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of taking the medication INH (Isoniazid)/ Rifampin (RIF).

_____ _____ _____
Client name, please print Date of Birth Today's Date

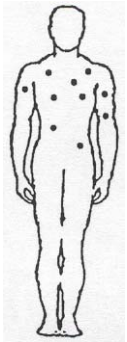
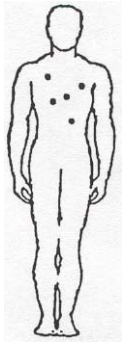
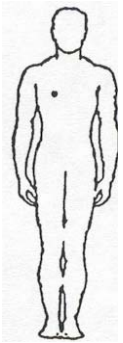
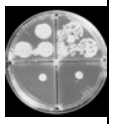
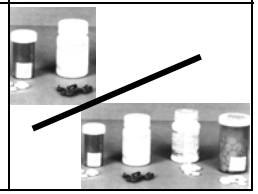
_____ _____
Client or authorized person signature Public Health Nurse Signature

List educational material given to client: _____

Gave client a copy of form: _____ (PHN Initials)

Usual Length of TB Treatment Plan

(teaching tool for TB nurses to explain to patients why they need to take medicine for so long)

When Diagnosed	1st Month	2nd Month	3rd Month	4th Month	5th Month	6th Month	. . . or longer
Sick ☹ 	**Better** 😐 	**Better** 😐 	**Feel well** ☺ 	☺ 	☺ 	☺ 	
Lab Tests  **Smear**  **Culture**	**+ + +** **(or -)** **+ +** **(or -)**	**+** **(or -)** **+** **(or -)**	**(-)** **(-)** **(or +)**	**(-)** **(-)**	**(-)** **(-)**		**Sometimes people need to take medicine longer:** **** Cavitary TB*** ****Culture + after 2months meds***
TB Medicine							

Developed by Evelyn Lancaster, RN, PHN - TB Controller Oregon: revised 5/03, 1/04

Tacoma | Pierce County
Health Department
Healthier. Safer. Smarter.

tpchd.org

3629 S. D Street MS 421
Tacoma, WA 98408

Tuberculosis Treatment Agreement

Name: DOB:
Address:

Your doctor is requesting that you take tuberculosis medications. The Health Department will provide the tuberculosis medications Monday through Friday by "directly observed therapy" (DOT). This means you must swallow all of the pills while the outreach worker watches. The pills cannot be left with you, or anyone else, to take later in the day. *There are no medications on weekends and holidays.* Your doctor will decide how many doses of medication you need for treatment and only doses you take by DOT are counted.

Together, we will agree on a time and place to meet for you to take your medications. If you cannot meet us, please call your outreach worker to arrange another meeting. If we are going to be late, or need to change the time of meeting, we will call you. It is important to take all of your medication doses in order to cure the TB.

Please do not plan any long vacations during your treatment course. If you must be out of town and need medicines to take with you, the Health Department requires one week's notice. You will receive one-half credit for each dose that is not supervised. Vacation will cause your treatment course to take longer. If you are gone longer than 2 weeks, the Health Department may have to transfer you records to your new residence.

Your tuberculosis might be contagious, so the Health Department will do TB skin testing. We will ask you about work, school and recreational activities to decide who needs testing.

Dr. Larry Schwartz or Dr. Marina Arbuck are in charge of your tuberculosis treatment, which includes prescribing your medications, ordering labwork and chest x-rays. If you have any problems with your TB medicines, please call the doctor at Infections Ltd., 428-8700.

Mary M. "**Peggy**" Cooley, MSN, RN
DOT Program Coordinator
253-798-2861

Sharon Reinsvold, BSN
Nurse Epidemiologist
253-798-7689

_____ _____
Patient or Representative Date

_____ _____
Health Department Representative Date

_____ _____
Interpreter Date

Tacoma- Pierce County Health Department
3629 South D Street
Tacoma, WA 98418
253-798-6410

ACUERDO PARA EL TRATAMIENTO DE TUBERCULOSIS

Nombre:_____ Fecha de Cumpleanos:_____
Direccion: _____

Su doctor requiere que usted tome medicina para la tuberculosis. El Departamento de Salud le suministrara (le dara) las medicinas para la tuberculosis de lunes a viernes a traves de "Terapia Directa Observada" (DOT). Esto significa que usted debe de tomarse (tragarse) todas las pildoras que se le den mientras un trabajador del servicio especial de asistencia publica lo observa. Las pildoras no pueden ser dadas ese dia ni a usted ni a ninguna otra persona para que sean tomadas mas tarde. No se entregan medicinas los fines de semana, ni los dias feriados. Su doctor decidira cual es la dosis que debe tomar para su tratamiento y unicamente las dosis que usted tome con el DOT son las que son contadas.

Juntos decidiremos a que hora y en que lugar nos encontraremos para que usted tome su medicina. Si usted no puede asistir a su cita por favor llame al trabajador de servicios especial de asistencia publica para arreglar otra cita. Si nosotros vamos ha llegar tarde o necesitamos cambiar la hora de la cita nosotros lo llamaremos a usted. Es importante que tome todas las dosis de la medicina para poder curarse de TB.Por favor no haga planes para salir de vacaciones largas durante el curso de su tratamiento. Si usted tiene que salir de la ciudad por fuerza mayor y necesita la medicina para llevarsela con usted, el Departamento de Salud requiere que se le avise con una semana de anticipacion . Usted unicamente recibira medio credito por cada dosis que no sea supervisada. Las vacaciones causaran que el curso del tratamiento tome mas tiempo. Si usted estuviera fuera por mas de 2 semana el Departamento de Salud podria tener que transferir su historia medica a su nuevo lugar de residencia (lugar de vacaciones).

Su tuberculosis puede ser contagiosa asi que el Departamento de Salud le hara un examen en la piel de TB. Le preguntaremos acerca de su trabajo, escuela y actividades de diversion para decidir quien o quienes necesitan hacerse el examen.

El doctor Marina Arbuck y el doctor Larry Schwartz en Infections Limited estan encargados de su tratamiento para la tuberculosis el cual incluye la prescripcion de la medicina, ordenar sus examenes de laboratorio y las radiografias de su pecho. Si usted tiene alguna reaccion o problema con su medicina para la TB por favor llame a Infections Limited al 627-4123 y reported al Dr. Arbuck o al Dr. Schwartz .

Firma	Fecha
Departamento del Salud	Fecha
Translator	Fecha

Case Management Treatment Plan for Active TB Disease

The purpose of this form is to provide a checklist to organize the gathering of information in a TB case to ensure the best medical and public health practices. Corresponding TB forms, both required and recommended, are listed with each component. (* denotes forms that are required by the state of Montana)

Patient Name _____ Date _____

___ Patient's contact information – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*

___ Assignment of responsibilities – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. TB Contact Investigation Report*
4. DOT – Treatment Record
5. TB Diagnostic Referral Form

___ Patient educator's name & dates of education – 1. Monthly TB Patient Assessment
2. Treatment of Active TB Education Form

___ Method for prevention of transmission – 1. Home Isolation Agreement

___ Planned course of antituberculosis drug therapy – 1. Confirmed/Suspected Report of TB Disease*
DOT plan
2.TB Case Monthly Report*
3. DOT - Treatment Record
4. DOT Agreement

___ Estimated date of completion of treatment - 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. DOT - Treatment Record

___ Test results from initial medical evaluation – 1. Confirmed/Suspected Report of TB Disease*

___ Medical history – 1. Confirmed/Suspected Report of TB Disease*
2. TB Case Monthly Report*
3. Monthly TB Patient Assessment

___ Diagnosis – 1. Confirmed/Suspected Report of TB Disease*
2. TB Diagnostic Referral Form
3. Bacteriology Data Sheet

___ Baseline tests, monitoring of activities, – 1. Confirmed/Suspected Report of TB Disease*
Drug therapy & side effects 2. TB Case Monthly Report*
3. Monthly TB Patient Assessment
4. DOT – Treatment Record
5. DOT – Adverse Reactions & Side Effects
6. Bacteriology Data Sheet
7. Biochemistry Data Sheet

___ Potential drug interactions - 1. TB Case Monthly Report*
2. Monthly TB Patient Assessment
3. DOT – Treatment Record
4. DOT – Adverse Reactions & Side Effects

___ Potential treatment adherence obstacles – 1. TB Case Monthly Report*
2. Monthly TB Patient Assessment
3. DOT – Treatment Record
4. TB Home Evaluation
5. Treatment Active TB Education Form

___ Personal service needs & social services referrals – 1. Monthly TB Patient Assessment
2. TB Home Evaluation

___ Referrals for social services - 1. Monthly TB Patient Assessment
2. TB Home Evaluation

___ Ensuring completion of treatment – 1. DOT – Agreement
Incentives, enablers, adherence 2. DOT – Treatment Record
3. Monthly TB Patient Assessment
4. Treatment of Active TB Education Form

___ Intermediate & expected outcomes – 1. TB Case Monthly Report*
Sputum & culture conversion 2. Monthly TB Patient Assessment
Symptom improvement 3. DOT Agreement

TB DISEASE MONTHLY PATIENT ASSESSMENT

Name: _____ DOB: _____ Date of Visit: _____ Interpreter: _____
Location of visit: Home___ Office ___ Other _____
Case conference last done on: _____
Type of TB: Pulm. TB Y / N **Date Of Last CXR: _____**
Extra-pulm. TB Y / N Site:_____ **Improved: _____**
Currently infectious Y / N **Stable: _____ Worse: _____**

Other Medical Conditions

None
Asthma Cancer
COPD Diabetes
ESRD GI
Hep C / Hep B HTN
Liver Pregnant
Other:_____

Tobacco use Y / N
Cessation Counseling Y / N

Medications / Changes

Anti-coagulants
Anti-hypertensives
Coumadin
HIV meds
Immunosupressives
Insulin
Oral Hypo-glycemics

Other: _____

Education

DX, Infection Vs. Disease_____
Transmission/Prevention_____
Meds: Resistance/Side Effects_____
General health care_____
HIV/AIDS information
Counseling & testing_____
TB & HIV_____
Diagnostic Procedures_____
Community Resources_____
Other:_____

Assessment

Weight:_____ B/P: _____
Pulse Oximetry :_____% LMP: _____

AFB:
Sputum ____ Urine ____ Other _____
Last date submitted: _____
Due:_____
Containers given for (date):_____
Problems: _____

Lab work drawn:
HFP
CMP Y / N
CBC Y / N
Other: _____ _____ _____

Vision check:
Distance: Rt._____ L._____
Both:_____ Glasses: Y / N
Color vision all plates seen: Y / N
Problems:_____

Hearing screening: Y / N Results:_____

Balance: WNL ABN

Reactions to Meds

Hepatotoxicity INH,RIF, EMB, PZA
Jaundice Y /N
Fever Y / N
Nausea Y / N
Light stools Y / N
Vomiting Y / N
Dark urine Y / N
Abd. Y/N

Hypersensitivity INH,RIF, EMB, PZA
Rash Y / N
Arthralgia Y / N

Non specific INH,RIF, EMB, PZA
Headache Y / N
Malaise Y / N
Fatigue Y / N
Anorexia Y / N

Neurotoxicity INH, EMB
Paresthesia Y / N
Dizziness Y / N
Visual changes Y / N
Distance Y / N

Hemolytic RIF
Bruising increase Y / N
Bleeding gums Y / N
Hematuria Y / N
Hematochezia Y / N

Psychosocial

Alcohol / Drug use_____
Behavioral / Mental Health _____
Homeless _____
Language barrier _____
Cultural barrier _____
Limited cognitive skills _____
Transportation _____
Long work hours _____
No insurance _____
Inadequate food/income _____
_____

DOT
Missed doses in past month _____
Problems:
_____
_____
_____
_____

Referrals:
_____
_____
_____
_____

Nurses' Comments:
_____
_____
_____
_____

Re-interviewed for more **contacts** Y / N Comments:_____
PHN Signature:_____ Date:_____

MONTHLY TUBERCULOSIS CASE REPORT

Submit 1st day of every month- *new information from last report only*

Today's Date:_____

Department of Public Health & Human Services
TB Program
Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Submitted By: _____

Agency: _____

Phone:_____

This Report is being submitted for: Month _____ Year _____

Patient Name: _____

City: _____ County: _____

Diagnostic Update:

Sputum Conversion: Collect until 3 consecutive negative results

Test	Date Collected	Result	Test	Date Collected	Result
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		
AFB Smear			M.tuberculosis Culture		

X-Ray: Date: _____ Result: _____

HIV: Date: _____ Result: _____

Other Tests: _____ Date:_____ Result: _____

Most Recent Medical Exam: Date:_____ Result: _____

Symptoms: ( ) Cough ( ) Productive cough ( ) Fever ( ) Night Sweats
( ) Chest Pain ( ) Weight Loss ( ) Other, specify: _____

Hospitalization: Date: _____ Admitting Diagnosis: _____

Medication - Treatment and Adherence:

DOT Plan (describe) _____

Self-Administration: _____

Breaks in Therapy: (give specific date, doses, reason)_____

List medication side effects:_____

Medication	Dose	Date Started	Projected Length of Therapy	Date Treatment Completed	Date Meds Dc'd and reason e.g. side effects, resistance, moved
Isoniazid -INH					
Rifampin - RIF					
Pyrazinamide - PZA					
Ethambutol - EMB					
Other:					

Therapy Completed & Case Closed: _____ (This will be the final report)

LTBI MONTHLY PATIENT ASSESSMENT

(LATENT TB INFECTION)

Name:_____ DOB:_____ Date of Visit:_____ Interpreter: _____
Location of visit: Home___ Office ___ Other _____
Case conference last done on:_____

Other Medical Conditions

None
Asthma Cancer
COPD Diabetes
ESRD GI
Hep C / Hep B HTN
Liver Pregnant
Other:_____

Tobacco use Y / N
Cessation Counseling Y / N

Medications / Changes

Anti-coagulants
Anti-hypertensives
HIV meds
Immunosupressives
Insulin
Oral Hypo-glycemics

Other: _____

Education

DX, Infection Vs. Disease_____
Meds: Resistance/Side Effects_____
General health care_____
HIV/AIDS information
Counseling & testing_____
TB & HIV_____
Diagnostic Procedures_____
Community Resources_____
Other:_____

Assessment

Weight:_____ B/P: _____

Pulse Oximetry :_____% LMP: _____

Other: _____

Chest X-ray: date _____

Lab work drawn:

HFP
CMP Y / N
CBC Y / N
Other: _____

Reactions to Meds

Hepatotoxicity INH, RIF, EMB, PZA
Icterus Y /N
Fever Y / N
Nausea Y / N
Light stools Y / N
Vomiting Y / N
Dark urine Y / N
Abd. Y/N
Hypersensitivity INH,RIF,EMB,PZA
Rash Y / N
Arthralgia Y / N
Non specific INH, RIF, EMB, PZA
Headache Y / N
Malaise Y / N
Fatigue Y / N
Anorexia Y / N
Neurotoxicity INH , EMB
Paresthesia Y / N
Dizziness Y / N
Visual changes Y / N
Distance Y / N
Hemolytic RIF
Bruising increase Y / N
Bleeding gums Y / N
Hematuria Y / N
Hematochezia Y / N

Psychosocial

Alcohol / Drug use_____
Behavioral / Mental Health_____
Homeless_____
Language barrier_____
Cultural barrier_____
Limited cognitive skills_____
Transportation_____
Long work hours_____
No insurance_____
Inadequate food/income_____

DOT

Missed doses in past month _____
Problems:

Referrals:

Nurses' Comments:

PHN Signature:_____ Date:_____

TB Case Management Monitoring Record (4/2003 sample)

Case name:_____ DOB_____ Rec #_____

LHD or PMD_____Phone_____ Fax _____

Diagnostic Evaluation: Symptoms *(circle all)* *Date cough started:* _____

Cough, **S**putum: thick/thin, color:_____, **H**emoptysis, **F**ever, **N**ight **S**weats, **M**alaise, **W**t.**L**oss of ____lbs

Diagnostic Microbiology:

	Date of spec	Type of spec	AFB smear	AFB culture	Susceptibilities
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____

TST: Date:_____ _____MM o Not done

CXR[6]: _____

TREATMENT PLAN: o 6 MONTH o OTHER: _____

Pt. Wt. =

(# months of treatment-→ NOTE: regimen & total # of doses determins when completes treatment)

	Start Month	1st month	2nd month[5]	3rd month	4th month	5th month	6th month	7th month	8th month	9th month
INH _____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
RIF _____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
PZA _____mg	_____	_____	____ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _
EMB _____mg	_____	_____	_____ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _	_ _ _ _ _
B6 _____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____mg	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
# DOT doses:	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

(Initial phase doses . . . . . / Continuation phase doses [pt should receive all initial phase doses first])

Self Administered (Standard of care is to be on DOT: only extremely rare circumstances would justify self administered)

 # doses injested/mo _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

MONTHLY MONITOR:

Side effects[1]	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Isolation[2] Yes/ n/a	_____	_____	_____	____ _ _	_ _ _ _ _	……	……	……..	……	…….
Smear status[3]	above	_____	_____	____ _ _	_ _ _ _ _	……	……	……..	……	…….
Culture status[4]	above	_____	_____	_____ _	_ _ _ _ _	……	……	……..	……	…….
Clinical Resp [5]	_____	_____	_____	____ _ _	_ _ _ _ _	……	……	……..	……	…….

Chest X-ray[6] . . . . . .3mo prn_____ . . .End of tx_____

MD/clinical Evaluation _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

[1] Side effects: ∅ = none noted, **P** = problem: see progress notes (symptom review, labs as ordered, visual/color while on EMB)

[2] Sputum smear positive cases should be isolated until non-infectiousness is established by: demonstrate a good clinical response to treatment, AND have been on adequate TB treatment for 2 weeks, AND have 3 consecutively negative sputum smears for AFB.

[3] Pulmonary cases: collect at least one monthly to document conversion to negative smear, then collect 2nd & 3rd to document non-infectiousness and release from isolation. Frequency of collection depends on severity of illness and diagnostic sputum smears.

[4] Pulmonary cases: collect one monthly to document conversion to negative cultures

[5] Clinical response: list letter code for persistent symptoms (eg/ **C** for cough), improved, or resolved. AFTER 2nd mo., eval the regimen.

[6] Initial: **C**=cavitary, **N**on-**C**avitary:infiltrates, scaring, nodules, etc ./ prn=improved, stable, worse / End= improved, stable, worse

PAGE_____

Client Name: _____**DOB**_____**Address:**_____**Phone:**_____**I.D.**_____

Clinical Path - Dx.: Positive PPD Physician: _____

KEY

D = Demonstrates X = Done
U = Understands I = Instruct/Reinstruct
C = Complies VR = Variance
0 = None N/A = Not Applicable
N/C=No Change / = Did Not Assess

OUTCOMES/GOALS:	DATE MET:	Signature	Initials
Client or caregiver will understand disease process and screening procedures			
Client or caregiver will verbalize understanding of significant occurrences and when to call health care provider			
Client or caregiver will follow-up with recommended medical care within ( ) days of nursing visit			
Client or caregiver will verbalize understanding of possible complications if follow-up not obtained			
Client or caregiver will leave with all questions relating to condition answered			
Client or caregiver will verbalize understanding of importance of finishing treatment			

Date					Nurse's Evaluation and Progress Notes
DIRECT CARE Initials					
Assess vital signs □ BP					
□ Pulse					
□ Respirations					
□ Temperature					
Allergies:					
Screening tests completed/Results:					
□PPD results _____mm Date:_____					
□Chest x-ray					
□Liver function					
□Visual Acuity					
□Sputum culture/gram stain/sensitivity					
Assess risk factors:					
□Medical conditions, including HIV					
□Living arrangements/Low income					
□Contact with people with active TB					
□Immigrants					
□Illicit drug use					
□Elderly or child < 4 years					
□Occupational exposure					
Assess relevant psych/social dimensions:					
□Insurance/income to cover screening & treatment					
□Able/willing to comply with treatment					
Assess for s/ s of medication side effects:					
□Loss of appetite					
□Dark colored urine					
□Jaundice					
□Rash/itching					
□Blurred vision					

Medication side effects (cont): Date					Nurses' Evaluation and Progress Notes
Unusual pain in hands/feet/joints					
Headache					
Dizziness/Drowsiness					
Nausea/Vomiting					
Convulsions					
General tiredness					
Assess for s/s of active TB:					
Cough					
Hemoptysis					
Chest pain					
Fatigue/malaise					
Weight loss					
Fever/night sweats					
INSTRUCTION AND INFORMATION					
Prevention recommendations:					
Finish medications					
Testing contacts					
Vitamin B6					
Future PPD/x-rays					
Educational materials discussed and given:					
S/s of active TB					
Medication sheets					
Signs and symptoms of complications					
Active vs latent TB					
Referrals made to:					
Physician					
HIV testing					
Follow-up appointment kept with/date:					
Medications (list) and DOT (as applicable):					
Confidentiality of Records per protocol					
Informed Consent per protocol					
Next PHN visit or follow-up call					

Tuberculosis Treatment Record
Directly Observed Therapy - DOT

Patient Name: ____
Public Health Nurse: ______________________________________
Agency: ____
Physician: _______________________________ _______________
Pharmacy: ____
Prescription: ____________________________ _______________
____

Date	Place of Visit	Prescribed Medications Oral meds/Dosage					*Adverse Reactions	Client Incentives	PHN Signature
		INH	RIF	PZA	EMB				

*** Adverse reactions = record on Monthly Assessment Form & consult with MD ASAP**

Tuberculosis (TB)
Directly Observed Therapy Agreement

To: _____ **D.O.B.:_____**
Patient name

Because it is very important that you follow the doctor's orders so that you are cured of TB, you are being placed in a supervised treatment program by your physician and the County Health Department.

This program requires that you:

Take your TB medicine while being observed by the Public Health Nurse or other designated staff as indicated below (days, time, and location):

LOCATION: _____
DAYS: **Monday Tuesday Wednesday Thursday Friday** (circle 2 days if bi-weekly)
TIME: _____a.m. / p.m.

We want to help you get better as quickly as possible and to protect those around you from getting TB. If you do not follow these directions for treatment, your condition could worsen and you could spread the disease to others. If you do not continue supervised treatment, the County may pursue legal action against you, which if convicted, may result in court ordered detainment for your treatment.

_____ _____
PHN or Designee Signature Date

I have read the above information, understand it, and agree to the conditions.

_____ _____
Patient's Signature Date

_____ _____
Interpreter Signature *(if needed)* Date

Copy given to patient _____ (PHN or Designee Initials)

Attachment C

DIRECTLY OBSERVED THERAPY RECORD

Name of Patient: ______________________________ **Isolation Residence:** ______________________________________

Date	**Time**	**Medication Given**		**Comments** (List any other meds given, and/or if contact was attempted and patient wasn't home)	**Staff Signature**
		Θ Isoniazid Θ Pyrazinamide Θ Pyrixodine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		
		Θ Isoniazid Θ Pyrazinamide Θ Pyridoxine (B_6)	Θ Rifampin Θ Ethambutol		

Attachment A

Idaho TB Contact Tracing Form—*Return with CDC "Report of Verified Case of Tuberculosis Follow Up Report-2"*

Case Name: _____ **Year Reported:** _____ **Number of Contacts Identified:** _____

List of contacts (use additional sheets if necessary):

Name	Relationship to Case (family, co-worker, etc.)	Date First Evaluated	PPD Tested?	PPD Result	CXR?	CXR Result	Infection status (uninfected, infected, active TB, or unknown)	Started on PPx? (INH or other)	Date PPx Started	Date PPx Last Taken	PPX Completed? If PPx not Completed, Reason*:
Bob Contact	*Brother of case*	*01/01/2000*	*Y*	*10mm*	*Y*	*Negative*	*Infected*	*Y – INH*	*01/06/2000*	*05/06/2000*	*No. 2*

***Reasons for not finishing PPx (pick the best option):** **1. Death; 2. Moved AND unable to locate for follow-up; 3. Adverse effect of medication; 4. Contact chose to stop despite indication for continuation of PPx; 5. Contact lost to follow-up; 6. Provider decision**

TB CONTACT INVESTIGATION REPORT

Today's Date: ____________________ Submitted by: ______________________________________ Agency: ____

Contact Risk Factors: 1. Household contact; 2. Less than 5 yo; 3. Contact has med risk factor (HIV); 4. Exposed during medical procedure; 5. Exposed congregate setting; 6. Exceeds duration environment limits; 7. CXR consistent with previous TB; 8. 5-15yo of age

Case Name: ____ County/Tribal/ IHS: ____

List of Contacts: 1. Name 2. Relationship to TB case 3. Address	**DOB**	**Contact Risk Factors And Dates** (see above)	**Initial TST**		**2nd TST** 8-10 weeks		**X-Ray** If patient less than 5 years old, must have both posterior & lateral x-rays		**Treatment of LTBI**		**If Treatment is not completed give reason**
			Date	Result mm	Date	Result mm	Date	Result	Med & Start Date	Completion Date	
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved – provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address
1. ____________ 2. ____________ 3. ____________											____ Death ____ Adverse Reaction ____ Patient Decision ____ Active TB developed ____ Lost to follow-up ____ Moved - provide address

Washington State Department of Health

Tuberculosis Contact Investigation Form

Submitted By:_____
Date:_____

Case

Name: (last) (first) (MI) (also known as)

DOB: | Age: | RVCT:

Morbidity Date:

County: | Comments:

Type: ☐ Pulmonary ☐ Non Pulmonary CXR Results: ☐ Cavitary ☐ Noncavitary

Contact

Priority of exposed contact

(please refer to CI Instructions for definitions)

☐ **Category 1: Smear positive or cavitary chest x-ray**

☐ **Category 2: Smear negative**

☐ **Category 3: Suspect case**

Contact Investigation

Date Identified:_____

Date Interviewed:_____

Date of Evaluation:_____

Contact Risk Factors (Mark Y =Yes or N = No in chart below)

1. Household
2. Less than 5 years of age
3. Contact has medical risk factor (i.e. HIV)
4. Exposed during medical procedure
5. Exposed congregate Setting
6. Exceeds duration environment limits
7. 5 - 15 years of age

Full Name of Contact	Date of Birth	*Exposure category	Household	< 5 years	Med risk	Medical exposure	Cong Set	Enviro limits	5 – 15 years	CXR- prev TB	TST Results/ QFT-G Results			Current Chest X-Ray	Treatment of LTBI	**** Completion Date or Discontinued Due to:
											**Prior Positive	Initial TST or QFT-G ***	8 – 10 week retest			
1.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
2.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
3.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
4.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	
5.												Date: TST mm: QFT-G:	Date: TST mm: QFT-G:	Date:_____ ☐ Normal ☐ Abnormal	☐ Yes Date:_____ Drug (s)_____ ☐ No Reason:_____	

***Exposure Category**
H= High
M= Medium
L= Low

****Prior Positive**
(1) = Follow-up needed
(2) = Follow-up not needed

*****Quantiferon-GOLD Results**
(1) = Positive
(2) = Negative
(3) = Indeterminate

******Completion date or discontinued due to:**
(C) = Completed treatment
(D) = Died during treatment
(L) = Lost
(M) = Moved & Records Referred
(P) = Provider Discontinued Meds
(R) = Refused to continue
(T) = TB Disease Diagnosed

TB Contact Investigation Summary

Due at the completion of each contact investigation - After all contacts on treatment for LTBI have completed therapy or have discontinued drug therapy

Montana Department of Public Health & Human Services
TB Program, Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date _____
Submitted by _____
Date Case Reported _____
County _____

Case Name _____

1. The case had: (check one)
   ___ pulmonary TB with AFB sputum smear positive
   ___ pulmonary TB with AFB sputum smear negative
   ___ non-pulmonary TB
   ___ other _____

2. Number of contacts identified _____

3. Number of contacts evaluated _____
   (initial TST placed & read, follow-up TST placed & read if indicated, and chest x-ray)

4. Number of contacts that were diagnosed with active TB disease as a result of this contact investigation _____ (This will trigger a separate contact investigation.)

5. Number of contacts that were diagnosed with latent TB infection (LTBI) as a result of this contact investigation _____
   a. Number that started treatment for LTBI _____
   b. Number of contacts that completed recommended treatment _____

6. For contacts not completing treatment for LTBI:
   a. Number who died before completing therapy _____
   b. Number who moved before completing therapy with no follow-up information _____
   c. Number who developed active TB disease during the course of therapy _____
   d. Number who stopped treatment due to side effects/adverse reactions _____
   e. Number who chose to stop treatment without any contraindications _____
   f. Number who stopped treatment on provider's advice _____
   g. Number lost to follow-up _____

Evaluation Indices for Contact Investigation:

1. Percentage of contacts evaluated _____ (MT goal: 95% of contacts to AFB-positive smear cases are evaluated)

2. Percentage of contacts who were diagnosed with LTBI _____

3. Percentage of contacts with LTBI who completed treatment _____ (MT goal: 80% of contacts with LTBI will complete treatment)

HOME ISOLATION AGREEMENT

Date: _____

Patient Name: _____ DOB: _____
Street Address: _____ Phone: _____
City/State _____ ZIP: _____

The above named patient has a communicable disease in a communicable stage and has been placed in isolation by their physician and/or the County Health Officer. Therefore, the following conditions must be followed:

The Patient agrees to:

1. Remain isolated to his/her private residence (or the address above) until determined to be non-infectious.
2. Not have contact with persons who do not reside at the above residence; therefore, visitors will be not be allowed in the residence until the isolation has been rescinded.
3. Allow TB Control Staff to monitor compliance with home isolation including unscheduled visits and phone calls.
4. Go to medically necessary medical appointments AND agrees to wear a mask when going to medical appointments until isolation has been rescinded
5. _____
   _____

Non-infectious status will be determined by subsequent sputum smears, compliance with TB treatment, and clinical response to treatment. Isolation will be rescinded by the County Health Department as soon as the patient is determined to be non-infectious and on adequate Directly Observed Therapy for tuberculosis.

I understand that if I fail to comply with these conditions, further legal action may be taken, possibly resulting in court ordered detainment. I have read the above information and understand it.

_____ _____
Patient's Signature Date

_____ _____
Interpreter's Signature (if needed) Date

_____ _____
PHN or Designee Signature Date

Copy given to patient _____ (PHN or designee initials)

SAMPLE: to use with all infectious TB patients
Print on letterhead

HOME ISOLATION AGREEMENT

Date: _____

Patient Name: _____ DOB: _____

Street Address: _____ Phone: _____

City:_____, OR ZIP: _____

The above named patient is reasonably suspected of having a communicable disease in a communicable stage and has been placed in isolation by his/her physician and/or the Pubic Health Administrator or Health Officer for the County. Oregon Revised Statute 433.010 Spreading disease prohibited states, "No person shall willfully cause the spread of any communicable disease within this state." Therefore, the following conditions must be followed:

1. The patient agrees to remain isolated to his/her private residence (or the address above) until determined to be non-infectious.
2. The patient agrees to not have contact with persons who do not reside at the above residence; therefore, visitors will be not be allowed in the residence until the isolation has been rescinded.
3. The patient agrees to allow TB Control Staff to monitor compliance with home isolation including, unscheduled visits and phone calls.
4. The patient may go to medically necessary medical appointments AND agrees to wear a mask when going to medical appointments until isolation has been rescinded.
5. Other:
   _____
   _____

Non-infectious status will be determined by subsequent sputum smears, compliance with TB treatment, and clinical response to treatment. Isolation will be rescinded by the County TB Program as soon as the patient is determined to be non-infectious and on adequate Directly Observed Therapy for tuberculosis.

I understand that if I fail to comply with these conditions, further legal action may be taken, possibly resulting in court ordered detainment. I have read the above information and understand it.

_____ _____
Patient's Signature Date

_____ _____
Interpreter's Signature (if needed) Date

_____ _____
Tuberculosis Control Staff Person Signature Date
(Revised Jan/04)

Instructions for Patients with Infectious Tuberculosis (TB)

Prepared by the Communicable Disease Control Program (208) 327-8625

People with infectious TB can spread the infection to others until medications have made the person noncontagious (not able to spread TB germs). This usually takes between 2 weeks and 2 months. It is very important to prevent others from getting infected. Until a public health worker from Central District Health Department tells you that you are no longer contagious, please follow these instructions carefully.

- **Stay isolated at your residence**.
  - You should stay at your residence except for doctor's appointments. If you have a necessary doctor's appointment with a doctor who does not know you have TB, you should inform the office staff ahead of time.
  - You should not be inside your residence or a car or a building with anyone who is not a member of your immediate household**.**
  - If you have to go to a doctor's appointment, you must wear a mask outside your home, when you're in a car with others and when you are inside the medical clinic.

- **Visitors should not come inside your home**.
  - In an emergency if a visitor must come inside your home, wear a mask when you answer the door. Warn the visitor that without wearing a mask, he or she is in danger of accidentally becoming infected with TB. Immediately give the visitor a mask when they enter your home. Both you and your visitors must wear masks the entire time they are there. Make the visit as brief as possible. Only in extreme emergencies should children under 5 years visit your home.
  - You may visit with people outdoors without wearing a mask. Stay at least one arm length away from others.

- **Do not go to work, religious services, school or other places.**

- **Cover your nose and mouth with disposable tissues when coughing**.

If necessary, the Central District Health Department will pursue legal action to attempt to make sure that people who are contagious with TB stay isolated until they are no longer contagious. Your signature below indicates you have received and understand these instructions.

_____	_____	_____
Patient	Date	Central District Health Dept. Rep.

ISOLATION INSTRUCTIONS

TACOMA-PIERCE COUNTY HEALTH DEPARTMENT

Name: DOB: Date:

Your doctor has determined that you may be/are contagious for pulmonary Tuberculosis (TB). This means that you are able to spread the disease through coughing, sneezing, singing or shouting. TB is spread when people share the same air in a room or house with a contagious person. TB cannot be spread by sharing food, hugs or kisses, clothing, eating utensils or bathroom facilities.

You need to stay at home until the doctor notifies you that you are no longer contagious. This time period is different for each person. Do not go into buildings where there are people, including stores, church, school or work. This isolation does not prohibit you from obtaining legal or medical services.

If you have no other alternative, you may go inside a building, **but you must wear a properly fitted mask.** The mask you wore at Infections Ltd. for your appointment is sufficient. When you enter a facility, you must notify them that you have contagious tuberculosis. If there are questions, call the Tacoma-Pierce County Health Department at 253 798-6410, then press "0". Wearing a mask at home is not necessary, because anyone who was in your household before you were diagnosed has already been exposed.

During the isolation period, no one should enter your home except those persons who live in the residence. The bacteria remain in the air and can infect persons even if you are not in the house.

The TB germ is killed by sunlight and is diluted by having fresh air move through the room. Please try to keep curtains, shades or blinds open to let sunlight in. During warm months, please open windows to allow in fresh air. Use tissues to cover your mouth and nose when coughing or sneezing.

We realize that this isolation may be difficult for you, however, it is important to safeguard the public's health, and this is the responsibility of the Health Department. Tuberculosis is a disease that is easily prevented if precautions are taken, and it can be cured.

If you have any questions, call Dr. Lawrence Schwartz, Dr. Marina Arbuck or the Health Department.

I have read and understand the above instructions and information. I agree to follow these instructions until notified by my doctor that I am no longer contagious.

_____ _____

Patient or Representative Signature Date

_____ _____

Health Department Representative Date

_____ _____

Translator Date

Tacoma-Pierce County Health Department
3629 South D Street
Tacoma, WA 98418
253-798-6410

INSTRUCCIONES PARA UN AISLAMIENTO
(INCOMUNICACION – CUARENTENA)

NOMBRE:_____ FECHA DE CUMPLEANOS:_____
FECHA:_____

Su Doctor ha determinado que usted (ustedes) puede (pueden) tener Tuberculosis Pulmonar (TB) contagiosa. Esto significa que usted (ustedes) tienen la posibilidad de propagar esta enfermedad a traves de un catarro, un estornudo, cantando o gritando. TB se puede propagar cuando la gente comparte el mismo aire en un cuarto o de una casa con alguien que este contaguiado (o sea que tenga tuberculosis).TB no se propaga compartiendo comida, abrazos o besos, ropa, utensilios para comer (cucharas, tenedores, cuchillos) o facilidades sanitariums (indoors, banns, lavatories).

Usted necesita quedarse en su casa hasta que el doctor le notifique que usted ya no esta contagiado (o sea ya no es propagador de esta enfermedad). El periodo de tiempo para la cur es different con cada persona. No vaya a edificios en donde hay gente, esto incluye tiendas, iglesias, escuelas o lugares de trabajo. El estar aislado (o sea durante el tiempo de asilamiento) no le prohibe a usted obtener servicios legales o medicos.

Si usted no tiene otra alternativa, usted puede entrar a un edificio pero debe usar una mascara que este propiamente ajustada. La mascara que usted usa para sus citas en Infecciones Ltd. es suficiente. Cuando usted entre en una facilidad (edificio) les debe de notificar de que usted tiene una tuberculosis contagiosa. Si tiene preguntas, llame al Departamento de Salud del Condado de Tacoma-Pierce al telefono 253 – 798 6410, despues marque el "0". No es necesario que use la mascara en su casa porque cualquier persona que viviera en ella antes de ser usted diagnosticado, ya estuvo expuesta al contagio.

Durante este periodo de aislamiento, nadie debe de visitar o entrar en su casa excepto aquellos que viven en la residencia. La bacteria permanece en el aire y puede contaminar a cualquier persona que entre aunque usted no este en la casa.

El germen de TB se puede matar con la luz del sol y es diluido (destruido) haciendo correr aire fresco a traves del cuarto. Por favor trate de mantener las cortinas o persianas abiertas para dejar entrar la luz del sol. Durante los meses calientes, por favor abra las ventanas para que permita la entrada de aire fresco. Use panuelos de papel para cubrise la boca y nariz cuando tosa o estornude.

Nosotros nos damos cuenta de que este aislamiento es dificil para usted, sinembargo, es importante proteger la salud publica y esta es la responsabilidad del Departamento de Salud. La tuberculosis es una enfermedad que es facil de prevenir si se toman precausiones y se puede curar.

Si usted tiene alguna pregunta, llame al doctor de Infecciones LTD (428-8700, o al Departamento de Salud.

He leido y entiendo las instrucciones e informacion arriba mencionada. Estoy de acuerdo en seguir estas Instrucciones hasta que el medico me notifique de que ya no estoy contagiado (por lo tanto no hay peligro deque contagie a nadie).

Firma Fecha

Departamento Del Salud Fecha

Translator Fecha

VOLUNTARY ISOLATION/QUARANTINE AGREEMENT

I, _____, date of birth _____, gender
(full name - please print legibly)

M__ F__, have agreed to be [ ] isolated
[ ] quarantined

at:

_____
(premises subject to isolation and quarantine)

pursuant to WAC 246-100-040 et seq. I understand that my isolation or quarantine

commences on (moment of signing) _____ and _____,
(date) (time)

and will remain in effect for _____ days, unless rescinded by the health officer.

I acknowledge that my rights have been explained to me, and that I understand the reasons that isolation or quarantine is necessary, namely:

Suspected Communicable Disease or Infectious Agent if Known: Tuberculosis

Medical Basis on Which Decision to Isolate or Quarantine Is Justified:

[ ] You are suspected of having been exposed to _____ and are potentially currently infectious to others.

[ ] You have been diagnosed with an active case of _____ and you are in all likelihood currently infectious to others.

[ ] Other: _____
_____

Special Instructions:
_____
_____
_____

It is very important for the protection of your own health and that of others that you abide by this Voluntary Isolation/Quarantine Agreement. If you have any questions about this Agreement or need assistance in complying, please call:

_____.

The Health Officer may seek your voluntary compliance, may mandate isolation or quarantine, or may petition the Superior Court for an order authorizing isolation or quarantine or continued isolation or quarantine for a period up to 30 days.

_____
Local Health Officer or His Designee
Tacoma-Pierce County Health Department.

IMPORTANT NOTICE

You have the right to petition the Superior Court for release from isolation or quarantine in accordance with WAC 246-100-055. You have the right to legal counsel. If you are unable to afford legal counsel, then counsel will be appointed for you at government expense and you should request the appointment of counsel at this time. If you currently have legal counsel, then you have an opportunity to contact that counsel for assistance. If you require a translator, one will be provided for you, and a copy of all relevant documents will be sent to you in an interpreted form. A complete copy of your rights shall be attached to this form.

I, _____, acknowledge that I have received a copy of the Voluntary Isolation/Quarantine Agreement, and that I have read or had read to me said Order and that I understand and agree to the terms therein. I further agree that I am voluntarily entering isolation or quarantine.

Signed _____. Dated this _____ day of _____, 20____.

Internal use only:

Dated this _____day of _____, 20___.
Date copies of Written Order was delivered to person or group of persons: _____. Method of delivery: personal service_____; registered mail_____. If the order relates to a group and the order is posted, date and location of posting:_____.

Aislamiento Voluntario/ Acuerdo sobre Cuarentena

I, _____, fecha de nacimiento _____
(Nombre completo, legible)

Genero M__ F__Yo estoy de acuerdo en [ ] aislamiento [ ] cuarentena

en:_____
(el lugar sujeto a aislamiento ó cuarentena)

conforme con la ley WAC 246-100-040 et seq. Yo entiendo que mi aislamiento ó cuarentena comienza en (el momento en que firme).
_____ y _____,
(fecha) (hora)

y se mantendrá en efecto por _____ days, recindible solamente por el Oficial del Departamento de Salud.

Mis derechos han sidos explicados y yo entiendo las razones por las que tengo que ser aislado ó puesto en cuarentena , nombrar la razón:

Agente Infeccioso ó Enfermedad Comunicable**: Tuberculosis**

Decisión médica por la que se ha decidido aislar ó poner a este paciente en cuarentena:

[ ] Se sospecha que Ud ha sido expuesto a _____ y puede infectar a otros.

[ ] Ud ha sido diagnosticado con un caso activo de _____ y existe la posibilidad que infecte a otros.

[ ] Otro: _____
_____

Intrucciones Especiales:
_____
_____
_____

Es importante para la protección de su salud y la de otros que Ud cumpla con el acuerdo de aislamiento ó cuarentena. Si Ud tiene alguna pregunta sobre este acuerdo ó necesita ayuda llame a:

_____.

El oficial del Departamento de Salud puede pedir su acuerdo voluntario, demandar su aislamiento ó pedir una orden de aislamiento ó cuarentena por un periodo de 30 days a la Corte Superior.

_____
Oficial de Salud Local ó persona designada.
Departamento de Salud del Condado Pierce

Noticia Importante

Ud tiene el derecho de pedir ser liberado de su cuarentena a la Corte Superior de acuerdo a la ley WAC 246-100-055. Ud tiene derecho a consejeria legal. Si Ud no puede pagar por un consejero legal, un consejero sera designado a Ud a costo del gobierno y Ud debe pedirlo en este momento. Si Ud tiene un consejero, entonces Ud tiene una oportunidad de contactarlo ahora y pedir asistencia. Si Ud require un traductor, dejenos saber. Copias de todos estos documentos seran proveidos en su idioma. Un acta completa de sus derechos estará adjunta.

Yo, _____, admito que he recibido una copia del acuerdo de mi cuarentena ó aislamiento voluntario y entiendo los terminos incluidos. Yo entiendo y estoy de acuerdo en comenzar mi aislamiento ó cuarentena voluntariamente.

Firma _____. Fecha _____, 20____.

Para uso oficial:

Fecha _____dia _____, 20___.
Las Ordenes Escritas fueron enviadas a la persona ó grupo de personas: _____. Metodo de envio: _____; servicio personal:_____; correo registrado_____. Si la orden se relaciona a un grupo y la orden esta al tanto, fecha y lugar:_____.

ORDERS TO VOLUNTARILY COMPLY
WITH TUBERCUORSIS CONTROL MEASURES
(sample2004)

PURSUANT TO THE AUTHORITY IN OREGON STATUTE, SECTION 433.006, 433.010, AND OREGON ADMINISTRATIVE RULES 333-019-000, THE PUBLIC HEALTH ADMINISTRATOR or HEALTH OFFICER OF _____ COUNTY HEREBY REQUESTS THE FOLLOWING:

ORDER ISSUED BY: _____ DATE: _____

Signature: _____ Title: _____of _____County

Orders Shall Remain In Effect Until Rescinded By _____.

ORDERS ISSUED TO:

Name of person: _____
Address: _____
_____, OR _____
Telephone No: (_____) _____-_____
Date of Birth: _____
Social Security No. _____ - _____ - _____

It appears to the Administrator/Health Officer that you have active TB or there are reasonable grounds to believe that you have active TB;
YOU ARE HEREBY ORDERED TO COMPLY WITH THE FOLLOWING TUBERCULORSIS CONTROL MEASURES:

	GENERAL CONTROL MEASURE	SPECIFICS
☑	Isolation to place of residence or other location ORS 433.006 and ORS 433.010 OAR 333-019-0000 Date Rescinded: ___/___/____	You are hereby ordered isolated at the following location on the following terms and conditions: LOCATION: Address _____ _____, Oregon CONDITIONS: 1. You must remain in isolation at the above location until you are deemed non-infectious (cleared) by the _____ County Health Department. 2. Until you are on adequate treatment for TB and are cleared by _____County Health Department, you may only leave your place of isolation to go to medical appointments or the hospital, with the condition that you wear your TB mask. You must return directly to your place of isolation upon discharge from the medical appointment or hospital. 3. No visitors, including visitors to other household residents, will be allowed to enter this location during the period of isolation. 4. Only the residents currently residing at this location may continue to reside there. No new residency can be allowed until you are on adequate treatment for TB and are cleared by ____County Health Department.

☑ Required medication and Directly Observed Therapy
ORS 433.006 and ORS 433.010
OAR 333-019-0000

Date Rescinded: ___/___/____

You are hereby ordered to complete the following appropriate prescribed course of medication:

1. TB medications must be taken once daily.
2. All the TB drugs will be dispensed and observed once daily as follows for the Initial Phase of treatment:
   Isoniazid (INH) _____mg
   Rifampin (RIF) _____mg
   Pyrazinamide (PZA) _____mg
   Ethambutol (EMB) _____mg
3. The Continuation Phase: The physician will adjust the medication regimen when culture and susceptibility results are known and after all the doses from the initial phase have been taken.

LOCATION: _____

DAYS: Monday-Tuesday-Wednesday-Thursday-Friday
(on Friday, a package of TB medicine for Saturday and a package for Sunday will be left for you to take on the appropriate day)

TIME: at _____am / pm

CONDITIONS:

1. _____County Public Health Staff will dispense your medication and observe you ingesting your medication at the above location, on the days specified above, at the time specified.
2. This schedule may be changed upon mutual agreement of you and _____County Public Health Staff:
   a.
   b.
   c.
   Phone number: (_____) _____-_____.
3. This schedule may also change to ingesting medication two times a week, upon recommendation of the physician, and when you can tolerate the increased doses.

☑ Exclusion from workplace or other place.
ORS 433.006 and ORS 433.010
OAR 333-019-0000

Date Rescinded: ___/___/____

You are hereby ordered excluded from the following locations on the following terms and conditions:

Work:
School:
Other: Any public building or place (except for medical appointments as discussed in the isolation section).

Once you are on adequate treatment and are not infectious, the _____ County Health Department will rescind this order.

☑ Additional orders
ORS 433.006 and ORS 433.010
OAR 333-019-0000

Date Rescinded: ___/___/____

1. Follow all TB control measures.
2. Appear at all appointments given you by your treating physician and by _____County Health Department.
3. Comply with your treating physician's requests for testing necessary to monitor your response to treatment and to monitor for side effects.

INDIVIDUALIZED ASSESSMENT OF YOUR CIRCUMSTANCES

The individualized assessment of your circumstances or behavior constituting the basis for the Administrator/Health Officer to issue this order is as follows:

List ALL details of your reasons for issuing orders: e.g./

1. You were prescribed TB medications that you did not take (dates of missed doses)

2. You currently are refusing to take your TB medication.

3. You are currently refusing : (medical exams (sputums, blood lab work, etc)

4. You were diagnosed with active TB in _____ and eloped from care before completing treatment.

5. Per your physician's report you have been non-compliant with other medical treatment recommendations:

a.)

b.)

c.) etc.

6. Unstable lifestyle: no permanent housing (living with friends, family, or at a shelter), unemployed, psychiatric diagnosis not well controlled, etc.

1. The following less restrictive treatment alternatives were attempted in your and were unsuccessful:

(Samples: if none, state so & give reasons for giving orders initially - e.g./ past history of non-compliances) (if past TB treatment history, list:)

a. Voluntary self-ingestion of TB medications (dates) with documented non-compliance (e.g./ pill counts off, pharmacy check = patient did not refill TB meds, etc.)

b. Voluntary attendance at medical appointments (PMD reported patient missed the following appointments:)

2. The reasons less restrictive treatment alternatives were considered and rejected in your are as follows:

A. Attempt at self-administration again. Rejected because:

1) TB is treatable and curable IF medications are taken as directed. If untreated, 25% of cases die within 2 years, 50% die within 5 years, 25% remain alive infecting others in the community.

2) Drug resistance can develop quickly if patients do not take their medication correctly.

3) If drug resistance develops, the chance for a successful cure decreases and could result in your death

4) Cases with a history of non-compliance with treatment usually continue with non-compliant behavior if treatment is not directly observed. *(add to statement, if appropriate: You have demonstrated non-compliant behavior in the past as discussed above.)*

B. Isolation at home without TB treatment. Rejected because: *(list reasons- see samples below)*

1) The patient does not live alone, and with untreated TB, could infect other residents of the household.

2) There are young children in the home. Young children infected with TB can rapidly develop fatal forms of TB.

3) The patient is currently medically fragile as evidenced by _____, and needs assistance with daily living so cannot live alone.

You are also ordered to submit to a photograph for purposes of identification. *(optional - if photos are possible)*

Failure to comply with this order may subject you to further legal action, including jail.

Signature of person serving notice:_____ Date: _____

Signature of patient: _____ Date: _____
(if case refuses, the person serving the notice should write that in on the patient signature line)

Signature of interpreter: _____ Date: _____
(if needed)

Interjurisdictional Tuberculosis Notification

Referring Jurisdiction city _____ county _____ state _____ Date sent ____/____/____

Contact person _____ Phone ( ) _____ FAX ( ) _____

☐ Verified case→State where reported: _____ RVCT# _____ (attach RVCT) ☐Not reported _____

☐ Suspect case ☐Close contact ☐Reactor LTBI ☐Convertor ☐Source case investigation

Patient name _____ Sex ☐Male ☐Female
Last First Middle

Date of birth ____/____/____ Interpreter needed? ☐No ☐Yes, specify language _____

New address _____ Hispanic ☐No ☐Yes
Number/Street/Apt. Race ☐ White ☐Black ☐Asian

_____ ☐Am.Indian/Nat.Alaskan.
City/State/ZipCode ☐Other: _____

New telephone ( ) _____ Date of expected arrival ____/____/____

New health provider: Unknown Known (name, address, phone) _____

Insurance source: None Medicaid Private Medicare Other _____

Emergency contact: Name _____ Phone _____

Laboratory information for this referred case/suspect index case for this contact not applicable

Date	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other pertinent labs

Site(s) of disease: Pulmonary Other(s) specify all _____

Date 1st negative smear ____/____/____ Not yet Date 1st negative culture ____/____/____ Not yet

TB skin test #1:Date ____/____/____ Result ____mm TB skin test #2: Date ____/____/____ Result____mm

Contact/LTBI Information **TB Skin test** Not Done

TST #1 Date ____/____/____ Result _____mm TST#2 Date ____/____/____ Result_____mm

CXR Not Done Date ____/____/____ Normal Other: _____

Last known exposure to index case ____/____/____ Place/intensity of exposure: _____

Medications ❒ this referred case/suspect ❒ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Planned completion date ____/____/____

DOT No Yes: start date ____/____/____

Daily 1x W 2x W 3x W

Last DOT Date ____/____/____

Adherence problems/significant drug side effects:

_____

_____

_____

Comments _____

_____

_____

Case Follow-Up In 30 days report to referring jurisdiction if located or not located and report final outcome.

Other Follow-Up Follow-up requested (form attached) No follow-up requeste

Interjurisdictional Follow-up Form

30 day status: □located □ not located

Return to:

Name _____ Fax number _____

Jurisdiction _____ Phone number _____

Patient name_____ Date of birth ____/___/___
Last First Middle

New address _____
Number Street/Apt. City State Zip Code

New telephone ( )_____ Sex: Male Female

Case: (Send RVCT F/U2 to reporting jurisdiction)

Completed: _____/____/_____ Moved to: _____
city county state

□Died □Lost (after initially located) □Never located

□Uncooperative or refused □Not TB □Other_____

Suspect:

□Verified by lab □Verified by clinical

□Verified by provider □Not verified

□Other:_____

If verified, and original jurisdiction submits RVCT, complete case outcome above.

Contact:

□No follow-up performed □Never located

□Evaluated: □ Class II □ Class III □Class IV □No infection

□Started treatment □Continuing treatment □Other:_____

LTBI/Convertor:

□No follow-up performed □Never located □Started treatment

□Continuing treatment □Other:_____